



# Homelessness Response System Authorization for Use and Disclosure of Information



This Authorization for Use and Disclosure of Information (“Authorization”) and the attached Notice of Privacy Practices (“Notice”) describe how your personal information may be used and disclosed by the San Francisco Department of Homelessness and Supportive Housing (HSH) and its partners. In addition, they describe your rights regarding your personal information. Please review these forms carefully.

As San Francisco’s Homeless Management Information System, the Online Navigation and Entry System (“ONE System”) is a shared, protected database and software application that enables HSH and its partners to collect and input client-level data, manage services, and generate reports. These functions help improve service delivery and coordination of client care, track client outcomes, and facilitate reporting requirements for persons experiencing – or at risk of experiencing – homelessness in San Francisco.

Personal information in the ONE System is protected and may only be used or disclosed in compliance with the attached Notice, with the written consent of the individual, or when required by law. Personal information in the ONE System may only be accessed by authorized personnel from HSH and its partners within the homelessness response system, each a “Partner Agency,” and collectively, the “Partner Agencies.”

## By signing this form, I understand the following:

- I understand that access to my protected personal information (PPI) and/or protected health information (PHI) may be limited by federal, state, and local regulations, including but not limited to, U.S. Department of Housing and Urban Development Homeless Management Information Systems Data and Technical Standards (2004) Final Notice (“HMIS”); the Health Insurance Portability and Accountability Act, 45 C.F.R., Parts 160 and 164 (“HIPAA”); California Welfare and Institutions Code Section 18999.8; and San Francisco Administrative Code Chapter 12M.
- I understand that access to my medical, HIV/AIDS, mental health, and drug and alcohol treatment records may be limited by federal and state regulations, including but not limited to, California Welfare and Institutions Code Section 5328, Confidentiality of Medical Information Act, California Civil Code Section 56.10 et seq (CIMA); HIPAA; and Federal Regulations Governing Confidentiality of Drug Abuse Patient Records, 42 C.F.R., Part 2.
- I understand that signing this Authorization does not guarantee I will receive services. I understand that except for programs that require personal information to determine program eligibility or assess needed services, I have the right to decline to disclose my personal information without being refused access to services. I understand that I may decline to sign this Authorization, but doing so may limit the services I receive.
- I understand I have a right to receive a copy of this Authorization and the attached Notice. I understand I have a right to inspect or receive a copy of my personal information. I understand I have a right to request a correction to personal information I believe is incorrect or incomplete.
- I understand I may withdraw my consent under this Authorization at any time. If I withdraw my consent, I understand that further information about me may not be collected, but it will not reverse or remove any information previously collected, used, or disclosed with my consent. I understand that if I withdraw my consent, service delivery and coordination of my services may be impacted.
- I understand that if I have questions about my personal information or my rights regarding my information, I may contact HSH at [hsh.privacy@sfgov.org](mailto:hsh.privacy@sfgov.org).

By signing this form, I authorize the following:

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- I authorize HSH, the Partner Agencies, and their authorized agents and representatives to collect, use, and disclose my personal information in compliance with the Notice, with my written consent, or when required by law. I understand that the Partner Agencies may change over time, and that a current list of Partner Agencies is available on the HSH website at: [www.sf.gov/hsh-partner-agencies-one-system-access](http://www.sf.gov/hsh-partner-agencies-one-system-access). I understand that the HSH reserves the right to amend the Notice and make the amended Notice effective for personal information collected, used, or processed as well as any information collected, used, or processed in the future.
- I authorize HSH to disclose my personal information to CCSF Homeless Adult and Family Multidisciplinary Personnel Teams (HMDT) for the purpose of expediting identification, assessment, and linkage to housing and services.
- If I am an enrolled member of a Medi-Cal Managed Care Plan, including San Francisco Health Plan (SFHP), Anthem Blue Cross, or Kaiser Permanente, I authorize HSH to use and disclose my personal information to my health plan for the purpose of providing or coordinating my health care and to administer coordination, authorization, and billing for CalAIM Community Supports.

Signature

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Authorization to use and disclose personal information shall be valid for three years unless noted below.

Full Name (Client): _____
Signature (Client or Legal Representative): _____ Date: _____
If signed by a Legal Representative, please provide:
• Full Name (Legal Representative): _____
• Relationship to Client: _____
This Authorization expires three years from the date of signature or the earlier date noted here: _____